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CDC Capacity Building Branch
Division of HIV/AIDS Prevention

Effective Behavioral Interventions
For HIV Prevention

Satellite Broadcast
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[From VHS]

Robert Janssen: I'm Rob Janssen, Director of the Division of HIV/AIDS Prevention, within the National Center for HIV, STD and TB Prevention at the Centers for Disease Control and Prevention in Atlanta. Welcome to our satellite broadcast on Effective Behavioral Interventions for HIV Prevention. This broadcast will highlight a variety of community-based organizations implementing science-based interventions.

The interventions we'll see today are Popular Opinion Leader, which is also known as POL, VOICES or VOCES in Espanol, Mpowerment project and Community PROMISE. We are committed to strengthening our program's capacity to deliver targeted, sustained and evidence-based HIV prevention interventions through our technology transfer efforts. HIV Prevention Technology Transfer is a process by which effective interventions are identified, disseminated and implemented in the field.

The targeted audience for these technology transfer products includes CDC's prevention partners, including health departments, community-based organizations, community planning groups and capacity building providers. Please, sit back, and for the next two hours allow us to present interventions for populations whose behaviors put them at risk, including men who have sex with men and young men who have sex with men, and African American and Latino heterosexuals.

Once again, thank you for joining us for this broadcast of Effective Behavioral Interventions for HIV Prevention.

Janet Cleveland: Hello. I'm Janet Cleveland, Chief of the Capacity Building Branch in the Division of HIV and AIDS Prevention at the CDC.

Ron Stall: And I'm Ron Stall, Chief of the Behavioral Interventions Research Branch, or BIRB, in the Division of HIV/AIDS Prevention at the CDC. HIV Prevention's strength among prevention providers implements scientifically proven interventions. The CDC is committed to supporting high quality behavioral science that identifies effective interventions.

Janet Cleveland: That's exactly right, Ron. Through capacity building and technical assistance, CDC is committed to increasing the proportion of providers who successfully deliver

effective, culturally competent, HIV prevention intervention. We're committed to diffusing these interventions to our partners and constituents and providing the capacity building support that was needed to implement these interventions.

Ron Stall: My branch, the Behavioral Intervention Research Branch, has identified a range of effective behavioral interventions. You'll find them in the CDC's compendium of effective interventions. Over the past several years, we've been working with researchers featured on today's broadcast to package their interventions, concepts and plans so they can readily be used by community-based organizations.

Janet Cleveland: We're endeavoring, through trainings and ongoing technical assistance, to support health departments, community planning groups and community-based organizations to enhance their ability to incorporate science-based interventions into programmatic activities.

Ron Stall: The transfer of these effective interventions requires a partnership between behavioral scientists, the CDC, prevention providers and communities.

Janet Cleveland: Ron, I'm sure that you'll agree that we look forward to today's exciting broadcast. I also look forward to our partnership with you, the viewer, and our future efforts to diffuse effective HIV prevention interventions.

Corinne Matthews: Welcome to Effective Behavioral Interventions for HIV Prevention. I'm Corinne Matthews.

Julio Dicent-Taillepierre: And I'm Julio Dicent-Taillepierre, and we're with the Capacity Building Branch, Division of HIV/AIDS Prevention at CDC. We'll be your moderators for today's broadcast coming to you live from Atlanta, Georgia. A special thank-you to Robert Janssen, Ron Stall and Janet Cleveland for their words of welcome and for conveying the importance of today's topic. We'd also like to thank all of the site coordinators for setting up their viewing sites and making it possible for us to reach so many of you for this broadcast on effective behavioral interventions.

For additional information on the broadcast, please visit the website at www.effectiveinterventions.org. In addition, we'd also like to provide you with some important reminders. One, HIV prevention interventions should always be culturally and linguistically appropriate. Two, HIV prevention programs targeting young people should utilize comprehensive health education messages that are consistent with community standards and include abstinence education.

Three, latex condoms, when used consistently and correctly, are highly effective in preventing the transmission of HIV. In addition, correct and consistent use of latex condoms can reduce the risk of other sexually-transmitted diseases. While the effectiveness of condoms in preventing HPV infection is unknown, condom use has been associated with a lower rate of cervical cancer and HPV-associated disease.

Corinne?

Corinne Matthews: Thank you, Julio. We have one final reminder. Today we will hear from various programs utilizing the interventions featured on the broadcast. They have adapted these interventions for their local populations. The June 1992 content of AIDS-related written

materials, pictorials, audiovisuals, questionnaires, survey instruments and educational sessions in CDC-assistance programs requires that organizations receiving CDC HIV prevention funds to prepare or distribute HIV prevention materials, establish a local program review panel to review and approve educational materials as defined in the guidance. These guidelines are available at www.cdc.gov/od/pgo/forminfo.htm. Please note, if you choose to use any of these interventions in your programs, you are required to submit the intervention package to your local program review panel for review and approval.

By the end of the broadcast we will: one, describe four effective behavioral interventions for HIV prevention; two, state the core elements of each intervention; three, state which target audience and populations are appropriate for these interventions; and, four, identify resources for further training and technical assistance. We will also hear from both the researchers as well as from programs around the country who are implementing these interventions.

Julio Dicent-Taillepierre: The first intervention we will highlight today is VOICES or VOCES, which stands for Video Opportunities for Innovative Condom Education and Safer Sex. This intervention was developed for sexually active adults. It was developed by Doctor Lydia O'Donnell, Senior Scientist at the Education Development Center in Newton, Massachusetts.

Lydia O'Donnell: VOICES is a brief, single session, video-based HIV/STD prevention program designed to encourage condom use and improve condom negotiation skills. This intervention has been shown to be effective because it reaches high-risk clients during a teachable moment, such as during a visit to an STD clinic, when they are likely to be thinking about their health.

Narrator: Alexi San Doval will now talk to us about the elements of the VOICES program. We will also hear from two organizations that are using VOICES with their target populations. The first organization, Action for Boston Community Development, is located in Boston, Massachusetts.

Alexi San Doval: VOICES consists of four pieces. The first is the use of videos as part of the intervention. We have two videos that specifically were developed for the intervention, one called Love Exchange, which was developed and tested with African Americans. It's an English video.

[portion of video text]

Female Voice: Speaking of protection, Coloni [phonetic], you know . . .

Female Voice: Oh God, Sondra, please, don't go there. Why are you nagging me?

Female Voice: I'm just saying, if something starts jumping out tonight you should be using a condom, a rubber. You know, I mean you haven't been dating anyone for awhile and there are diseases out there.

[end of video text]

Alexi San Doval: The second video, Porque Si?, is a bilingual Spanish and English video which was developed and tested for a bilingual Spanish speaking audience.

[portion of video text]

Male Voice: You know, talking about AIDS and condoms when you're with a girl, I mean it spoils the moment, man.

Male Voice: You can spoil your whole life if you're not using condoms. [Spanish dialogue; unable to translate] Do you feel lucky today?

Male Voice: Very lucky.

Male Voice: Well, maybe you bet your whole life last night and you don't even know it.

[end of video text]

Alexi San Doval: VOICES also has a second core element, which is basically pulling together and delivering small group discussion using the messages in the video to trigger discussion with a small group of four to six participants.

[portion of video text]

Female Voice: [Spanish dialogue; unable to translate]

[end of video text]

Alexi San Doval: The third piece of VOICES is a condom features poster, which is really used to tie in to the discussion any concerns or issues related to patients' resistance to using condoms. And the last core element is provision samples of the different types of condoms that are featured on the poster. VOICES can be adapted in certain ways as long as one maintains the fidelity of the core elements. The advantages of using VOICES is its low maintenance, low cost, low staff intents.

The great thing about VOICES is that if you have a person in the clinic who can run a group, basically organize four to six people. You don't need a special setting for it, a special room. You just need a little private space for 45 minutes to show the video. Community-based organizations can do this. It can be done in STD clinic settings. It's a single session, and I highlight single session because folks don't have to come back for it. It's one-stop shopping.

Some people may have reservations initially about how this intervention can be adapted or integrated into their facility. It takes time as with any intervention or any new program that's being introduced. If you're able to work with patients or clients in any setting where STD/HIV prevention services are being delivered, VOICES can be relatively easily integrated into the flow of the services that are being provided.

Dorothea Keeling: I use VOICES in a variety of different settings. I particularly use it within the correctional system. I go into the prison system. I use it in transitional care facilities in which people are there for addiction. I use it in shelters of women who go in because they were being battered. And then I use it in the community at house parties.

Irvienne Goldson: At Action for Boston Community Development, ABCD, we're a non-profit social service agency. ABCD uses VOICES in a number of different ways. We use VOICES in hair salons where we go in and while customers are waiting to get their hair done we conduct brief education with the customers. We use it with women who we have trained to be facilitators of home-based safer sex parties.

Maridena Rojas: The Safety Net party is a home-based party program based after the Tupperware party where different women get together and they get to talk about safe sex issues

or issues relating to sex and their sexual identify and how to maintain safety against HIV infection, sexually transmitted diseases and the HIV virus. When we get to the part of the Safety Net party where we use the VOICES video, we watch the video first because it's a 15-minute video.

There are different techniques to use with VOICES. You can stop at a certain key point or you can view it all the way through and then have discussion about it. We do role playing, so we would have a woman act like a man, giving all the barriers of why you don't want to use condoms, and the women are kind of challenging him why you should use the condoms.

Irvienne Goldson: It's a well-developed curriculum that looks at the different core competencies of the curriculum, that even gives a participant evaluation form that gives scripts, everything that you could think of needing in terms of implementing the program.

Narrator: The next program we'll see is Families Under Urban and Social Attack located in Houston, Texas.

Riva Okonkwo: We're using VOICES at Families Under Urban and Social Attack, which is FUUSA, to provide intervention to heterosexual, male and female. We offer the curriculum in different types of settings.

Narrator: Acres Home Barber College is the oldest African American-owned barber college in Houston, Texas. Families Under Urban and Social Attack uses the VOICES intervention with students at the college.

Amana Turner: When we started over at Acres Home Barber College back in '98, we were only doing targeted street outreach and that was one of our sites. The owner of the barber college talked to us to see what we were doing out there. So we said we are giving information on HIV prevention to heterosexual men and women in our community. So he allowed us to come on the property and talk to the guys, the students, and then he allowed us to come on the inside to sit and do groups.

When we have educated those in to do the VOICES, she goes in and she sets up the classroom with the VCR, with the VOICES posters, then she will explain to them about VOICES, what VOICES is all about, and from there she will start the video. Then it's discussion time, because there has to be interaction from the participants because they are the one that makes up the class.

[portion of video text]

Sheila Parker: So how many times have we been out and we really didn't plan it, didn't have a condom with us? Okay, come on. Tell me the truth.

Male Voice: Too many times.

[end of video text]

Sheila Parker: Taking VOICES to the barber college or other locations that we go to, the client is more relaxed, therefore maybe a lot more comfortable disclosing information as opposed to them coming to FUUSA and doing the VOICES program there. They might not be as willing or open to disclose personal information because of the atmosphere is different.

[portion of video text]

Male Voice: I think of a situation where the flesh actually took over, and anytime you get to that stage without actually having protection on you handy the flesh more than likely will win if that's what you're giving into.

[end of video text]

Amana Turner: FUUSA has adapted the VOICES program into our existing program we have already established to go in and do group presentations. We adapted the programs where it could fit into the emergency shelters, the transitional living facilities, we adapted the program for apartment settings, outpatient treatment setting and also in-patient treatment facilities.

[portion of video text]

Female Voice: Yes, men a lot of times will tell you, too, that it don't feel right if they use a condom. Come on, let me do it. You know?

Female Voice: She should have used a condom anyway, alright? She didn't know him; she just met him. You know? And she don't know nothing about him, ain't never seen him.

[end of video text]

Narrator: The video is used as a trigger to generate a facilitator-led brief discussion that lasts about 20 minutes. The facilitator follows a guide that helps participants discuss how to use condoms and get partners to use condoms in different situations. The facilitator may ask how they would get a partner to use condoms if they were in situations like those portrayed in the video. Is that realistic? What would you say? What would you do differently? Would that work for you? In this way, group members help each other come up with ways to convince partners to use condoms.

Sheila Parker: The rewards of seeing that VOICES is effective with our population is knowing that we are making a difference, that we are helping to convey information and helping the people to develop skills and ways to reduce their risk for HIV infection.

Corinne Matthews: Thank you to Doctor San Doval, Action for Boston Community Development and Families Under Urban and Social Attack. Our second intervention today is Popular Opinion Leader or POL. POL is an intervention based on a program that identifies, trains and enlists the help of key opinion leaders to change risky sexual behavior and norms. We are joined by Doctor Jeffrey A. Kelly, who will talk about the core elements of POL.

Jeffrey Kelly: The Popular Opinion Leader intervention, POL, begins with the concept that within any population of people there are certain people that are naturally well liked, respected, people whose opinions are valued, within a community population. The idea is for key popular, well liked people to talk with their own friends and talk about risk for AIDS, but more importantly, to endorse the benefits of avoiding that risk. That can create a shift in the risk behavior and the risk attitudes within the whole population.

The POL intervention requires that an agency first identify the target population with which they'd like to work, then identify the community settings or venues where members of that type of population normally socialize and hang out and spend time.

Scott Haverstock: In Phoenix, we use the POL program. We target the bear and leather community, which is a community that's basically a subgroup of the MSM population. The

reason that we are targeting that population is because Phoenix is such a large area, so we picked a subgroup.

Jeffrey Kelly: It's then essential that we teach opinion leaders how to communicate effective health communication messages during everyday conversations with their own friends and acquaintances.

Scott Haverstock: The bear and leather community, usually men who have hair, that they can be larger, and they don't necessarily fit into the subgroup of what the media portrays as the standard gay man . . . young, thin. The leather community is a community that's defined more as their social roles. It's the actions of how they socialize and it can be sexual.

Jeffrey Kelly: Communities differ enormously in their culture, in their risk behavior, in values and needs, but there are certain people whose opinions are naturally valued. These opinion leaders are present really in every culture in every community, so in that sense the intervention is very cross-culturally applicable.

Cindy Vargo: One of the modifications we've made in the Phoenix area is included women and individuals who are transgendered in the POL program. Our target population here for the POLs are leather and bear community and we've found that women, in particular, are very important in those communities and they are the influencers in many cases.

Jeffrey Kelly: We also know that the way people talk, the things that they talk about, language they use, risk behaviors that are involved, are very specific to a population. So the intervention has to be tailored to meet the needs, the values, the language of the community with whom one works.

Scott Haverstock: With the bear and leather community, we have been able to adapt the POL. It did take some planning. We did have to run some focus groups and there were a lot of changes that we had to make from the original POL plan.

[portion of video text]

Female Voice: Now we've got your condoms, we've got some lube.

[end of video text]

Scott Haverstock: We have an outreach kit, a safer sex kit, and this one targets the bears and what we do is we put prevention message, condoms and we also will promote the POL program, which we have larger cards which describe the POL program. This one targets the leather community, this one targets the bears, and then we have the smaller business cards which says leathermen wanted, bears wanted, and those will target the community.

Jeffrey Kelly: Agencies that wish to implement the POL intervention should consider the scale of the intervention. We find that it's critical to train 15 percent of the members of the target population as opinion leaders in order for the intervention to have an effect and, therefore, the size of the program should depend on the resources of the agency.

Scott Haverstock: With the POL intervention here in Phoenix, what we're finding is that the familiar face and the familiar situation, the familiar environment, is key to these individuals digesting the safer sex message, which is different than, say, if an outsider, the county health

department, an AIDS service organization like Body Positive, was to go into that situation, that environment, and give the safer sex message.

Jeff Wilson: I've been positive for almost 21 years. I've been dealing with AIDS for almost 21 years, had the ups and downs with it as I go around and I'm now suffering with cancer. As a Popular Opinion Leader, it's easier for me to talk to them about HIV and AIDS. Being 21 years positive has a lot to do with talking to the younger generation about becoming HIV positive, so it gives them the incentive to want to stay healthy and do healthy things.

Scott Davey: When we looked at Tucson, we looked at HIV and we didn't want to put it in its own little box by itself. When we think of HIV, we also know that substance abuse, domestic violence, those kinds of issues all play together. So when you're talking to somebody about changing their safer sex behaviors and keeping them safe, if they're using drugs that's a huge component that they could make bad decisions and not play safe.

When we thought of POL and adding other health issues such as substance abuse and cancer, it really gives men the thought that we have to look at our health overall instead of just I have one problem and I'll fix it, because it doesn't work that way.

Jeffrey Kelly: In AIDS prevention, we often think about the problems of communities that are at risk for HIV, and there are problems. But the POL intervention relies on another notion, which is that communities also have strengths. The strength is that they have members of the community that want to do something to help.

Scott Davey: The peer piece is the most important piece. When I talk about the peer piece versus a paid official, when you're a paid official you're supposed to tell them what they're supposed to do to make themselves healthy. So, in a way, people don't listen to you because they know you're being paid to do that. But the peer piece, the thought is that your friends really care about you and that they want to see you well and happy and healthy.

From a public health standpoint, I come in, maybe one time I see you, I give you a bunch of information and then you're on your way. There's not a lot of follow up because there's not a lot of resources for that, but with a peer there's constant follow up because you're always interacting with that person on a daily or weekly basis. So the cost effectiveness with POL is actually a positive because we don't have to hire staff. We're using a core base of volunteers to come in, do the training and then go out and talk to their peers.

Jeffrey Kelly: We invite those popular people to come to training programs to teach them how to deliver effective health communication messages to their own friends in everyday conversations.

Scott Davey: The peer piece of the training is incredibly important, and that is the way that we're going to change people's behaviors. But when we looked at Tucson, we had to decide to do a one day training versus the original four week training in that we had to add other health components to it instead of just focusing on HIV.

Jeffrey Kelly: This is an intervention that is not brought by an external agency to a community. Rather, it works with people in the community to become AIDS prevention

advocates to others and, therefore, it has to fit. The language, the approach and the communication styles in the lives of people that one hopes to work with.

Narrator: Now let's review the core elements of Popular Opinion Leader. Identifying and enlisting opinion leaders to take on risk reduction advocacy roles, training opinion leaders to disseminate risk reduction messages in their social networks, and supporting and reinforcing opinion leaders to help encourage safer sex.

Corinne Matthews: Thank you, Doctor Kelly. The Southern Arizona AIDS Foundation and Body Positive. The facilitator for the next portion of the broadcast is Janet Cleveland, Chief of the Capacity Building Branch at CDC. Janet?

Janet Cleveland: Thank you, Corinne. Joining us for our first panel discussion today is Velia Leybas-Amedia, Associate Director for Prevention, Southern Arizona AIDS Foundation in Tucson, Arizona. And also, Doctor Charles Collins, the Science Application Team Leader for the Capacity Building Branch in the Division of HIV and AIDS Prevention at CDC. Also joining us by phone are Doctors Lydia O'Donnell, Senior Scientist, and Alexi San Doval, Senior Program Director, Associate Center Director at the Educational Development Center. Let's begin. Our first question is actually for Alexi San Doval. Alexi, can you do the group activities that have been described today in Spanish? And also, what materials are available in Spanish?

Alexi San Doval: Yes, the group activities, as with the entire intervention, the materials are packaged in both English and Spanish so these are available. We have the VOICES of intervention obviously aimed at two populations, Spanish speaking, a bilingual Spanish speaking population and non-Spanish speaking. So they are available. The facilitator's training guide, that's their curriculum to train the facilitator on how to deliver the intervention, is bilingual. Also, the video obviously is bilingual and the condom features poster is bilingual.

Janet Cleveland: Thank you very much. Our next question is for Doctor Lydia O'Donnell and this question refers to also VOICES, and the question is 20 minutes for a group is very short. What can be covered in that amount of time?

Lydia O'Donnell: People are often surprised how much can be covered in 20 minutes and that's one reason we use the video first, because it helps focus attention on the key messages we want to get across and also on the key skills that we would like people to practice before they leave. So it's a very focused, targeted 20-minute session that really addresses issues of getting yourself convinced to use condoms, convincing your partner to use condoms. What you would do, how you would say it, what verbal and nonverbal ways you would try and convince partners in different kinds of relationships to use condoms.

So there's actually quite a bit of practice about trying to make sure that when you go out of this group you're prepared to do something differently and protect yourself and your partner in the future.

Janet Cleveland: That's very good. Thank you so much. We're going to switch over to some questions about the Popular Opinion Leader, and I'm going to refer this question to Doctor Charles Collins. Charles, what are some of the challenges to implementing the Popular Opinion Leader?

Charles Collins: Well, I think that some of the challenges that are involved with the Popular Opinion Leader is that there has to be a period of time in which you're really looking at the community and observing the community to find out who the Popular Opinion Leaders are in the community. You want to identify roughly 15 percent of the community that are the people that other people in the community listen to for advice, and so you need to get the right people. And so I think that's one of the challenges.

I think a second challenge is that once you get the program going, you need to continually try to recruit the next group of Popular Opinion Leaders so that the program continues to grow in the community and so that healthier norms spread through the community. So I think those are probably two of the greatest challenges for this very effective intervention.

Janet Cleveland: Okay, very good. I'm going to switch over to Velia Leybas-Amedia, and I'm going to ask from this viewer what strategies have you used to encourage youth to diffuse health messages to their peers?

Velia Leybas-Amedia: We had a pretty creative solution to that. What we did is once our young people finish our training program, we create a contest. We have a graduation after the training program and what we do is we give mall certificates or music certificates, also movie passes. And we create this sort of competition to see how many prevention conversations can they have before our graduation and that seems to be the most effective way to do it with our young people. It motivates them too.

Janet Cleveland: Okay, and when you say that it motivates them, how does it motivate them and what does that mean for you in terms of the implementation of the intervention?

Velia Leybas-Amedia: Well, if we have a group of about 11 young people finishing a program, it creates a little competition among those 11 to see who can have the most prevention conversations with their peers. And so they find that out at the graduation and they like talk with each other and find out well, what did you talk about and what did you say to so-and-so? So it creates this nice little competition and sharing between them.

Janet Cleveland: Okay, wonderful. Thank you very much. We have a fax in from California for Lydia, and the question is, Lydia, what behavioral models were used to design the VOICES intervention?

Lydia O'Donnell: We based it on several social cognitive models, including the theory of reasoned behavior, that we really wanted people to identify the different reasons or different things that may come in the way of them using condoms and bring those more to their recognition of how they would behave in the future so that they could think about those different reasons and practice ways to both address them and try to figure out why they should be protecting themselves and other partners in the future.

So we really tried to have people think about different relationships. Whether they were in a main relationship and a long-term relationship with someone or they were having relationships with a new partner or multiple relationships, to think about using condoms in that specific relationship. And what kind of steps they would need to take to try and make sure they and their partners were protected in the future.

Janet Cleveland: Now one might ask how difficult was that undertaking, particularly when you're talking about working with young adults, even older adults? It would seem that that would be somewhat difficult. Could you just expand on that a little bit please?

Lydia O'Donnell: Sure. One of the reasons that we used videos is that we were able to portray that variety of relationships. So in each of the videos, both Porque Si? and Love Exchange, you see people in a new relationship, you see a longer term relationship, who are basically not able to use condoms when you first see them and then you really see them trying to work out ways to talk to their partner or communicate either non-verbally with their partner that in the future they have to protect themselves. So the videos provide you with some common themes that we develop with community partners.

We developed these videos by working with community members and advisory boards and screening and doing rehearsals with members of the community there of different ages, from our young adult population to even older adults. And they helped us shape realistic types of situations and relationships where people often find it very difficult to use condoms. And then we asked, even in developing the videos, people to think about ways that they would try realistically to get their partner to use condoms or use condoms themselves, and that is also something we tried to model in the two videos.

And then when the videos stop it's time for the people in the group to take over and say was that realistic? Is it different from you? Are you in a different kind of relationship or would that sentence or line work for you? What if your partner says oh, no, I trust you, we don't need to use condoms anymore. What would you say back? So it's a very targeted group that basically has people focus in on the kind of relationship that they're in and how they would deal with trying to reinforce condom use over the long term, consistent condom use with their different partners.

Janet Cleveland: That's very helpful. Thank you so much for that, Lydia. The next question that I have is actually for Alexi San Doval and, Alexi, the question that is being posed is what type of impact evaluation has been done as follow up to determine participants' change in knowledge, attitude and behaviors in terms of your work? And, of course, we know that evaluation is a very critical portion of our program efforts, so could you please address that?

Alexi San Doval: What type of impact evaluation has been done in terms of follow up?

Janet Cleveland: Yes, to determine participants' change in knowledge, attitude and behaviors.

Alexi San Doval: Well, some of this I think probably I'm going to defer to Lydia on this to address some of this. Essentially what we've done is, in terms of part of the dissemination plan that we have in place, has been really to get this out into the community and to work and hear from folks, some of those whom have actually participated in the taping of this session. And you saw from examples, based on their stories, of how they've actually implemented it in their communities, how they're using VOICES and the kind of creative strategies they're using to get the message out there around condom promotions. And I'd like to probably just ask Lydia to provide some input to this question as well.

Lydia O'Donnell: Certainly, and I think that you are also interested in that question in finding out what we learned about VOICES and how it can be effective when used in different situations. Our main field studies show that when you use VOICES in STD clinics and with clients who are similar to those who are served in STD clinics, that is they engage in unprotected sex, we could see not only increased knowledge about transmission of HIV and other STDs and better attitudes about using condoms. But very importantly, we saw a reduction in new STD infections when we followed people over time. So those people who were involved in the VOICES brief intervention, who just came to the one session and participated in that one session, when we followed them out for months and months after that we saw that they were less likely to get a new STD infection than were a control group.

So we've shown both that there seems to be a biological outcome, as well as some other positive behavior steps. We also saw that people who participated in VOICES were more likely in a control group to go to neighborhood stores and actually get some condoms. And so we tracked that as well.

And finally, we've also been able to look at whether VOICES is cost effective, that is, by putting on VOICES in your agency and providing it to clients. When we model that does it seem like you would wind up saving money over the long-term or that we in the U.S. who are dealing with such an HIV epidemic among certain communities now, would save money if we adopted a session like VOICES. So could something, even brief, even one session, be effective and be cost effective when used? And we show that, indeed, it is and could ultimately wind up in a cost savings as well as saving lives and reducing infections.

Janet Cleveland: Thank you very much for that, Lydia. Cost effectiveness is something that we are having to deal, of course, more and more with and always there are questions that are coming to us about the cost effectiveness of intervention. So thank you very much for addressing that and including that piece of information as well.

I'm going to direct the next question actually to Doctor Charles Collins, and this is involving POL, of course. And Charles, the question that has been posed is what behavioral theory supports the effectiveness of the POL?

Charles Collins: Well, the POL is actually based on the theory of diffusion of innovation, a theory developed by Everett Rogers, and that theory is really a very basic theory and it says that community norms can be changed if you are able to work with a core group of opinion leaders in a community who can then influence the rest of the community.

And so, you know, there's many norms that could be spread through a community. There could be norms about condom use. There could also be norms about abstinence. I mean norms, there's normative behavior and it can be spread throughout a community. So a program out there that wants to do the Popular Opinion Leader needs to really think about what are the healthy norms they would like to have spread and then to recruit the opinion leaders to help spread those norms through the community.

Janet Cleveland: Okay, that's very helpful. And I'm also going to turn to Velia and just play off of what you have just said. Because, Velia, what I'm wondering is in your program how

does the issue of community norms and infusion of health messages into the model actually come about with work that you're doing and the populations that you're working with?

Velia Leybas-Amedia: We do that actually. Let me just describe our training because that'll help explain it.

Janet Cleveland: Please.

Velia Leybas-Amedia: We have five weeks of training, which is after school for an hour-and-a-half twice a week, and then following that we have a three-day retreat which is where we implement the HIV prevention piece of it. And that's the time that we talk about HIV prevention and we also teach skills in diffusing or how to practice safe sex and negotiation, and so that's where their health messages come in.

The strongest health messages come during the retreat when it's a time to be intimate with one another. And it's comfortable because we're in a setting far away from normal home or school. So that's when we address these pretty tough health issues, that's when we address those.

Janet Cleveland: And you said that the persons come to the trainings five days a week after school?

Velia Leybas-Amedia: Twice a week for five weeks.

Janet Cleveland: Twice a week for five weeks? Okay. How do you actually get these young people to come for these trainings two days out of the week after school?

Velia Leybas-Amedia: That's an excellent question. We do similar to what I've been hearing Charles describe. We do look at our Popular Opinion Leaders in a school and the people who identify them are students themselves. So we talk with young people about, can you make the commitment to come two days after school, are you willing to do that, and this is what you'll give back to your community.

So we find out first if they're willing to do that and make the commitment, and once they are they stick with it. Plus we have incentives, incentives as like becoming a credible peer leader, we have a meal for them after school, they get to go on this retreat. So there are lots of incentives along the way and that's how we do it.

Janet Cleveland: Okay, that's great. And then I'm going to come right back to Charles and ask how would you identify Popular Opinion Leaders? We've heard a little bit about how Velia has done it, but, of course, this intervention is appropriate for many different populations.

Charles Collins: That's exactly right. I mean Velia gave a good example of doing the Popular Opinion Leader with middle school children where you may observe who eats with who in the lunch room and that kind of thing to decide who the popular kids are. But I know that one program that did the Popular Opinion Leader did it in public housing and they looked to just see who were the women who lived in the public housing that were popular based on their interactions at the playground, their interactions in the Laundromat. You know, they were able to just observe the community and they were able to see who in the housing project were the women that other people came to for advice and so that was one way that they identified.

Now the Popular Opinion Leader has also been used in the gay community and so one of the things that's done is to go into the clubs and observe people: Who is talking to who, who in

the club seems to know everybody. If you see somebody come into a nightclub and they know 15 or 20 people in that nightclub, that is probably going to be a Popular Opinion Leader and that's a person you would want to help you with your intervention.

Janet Cleveland: That's helpful. Thank you both very much. I'm going to ask you to go back to the phones, and we have a question for Alexi San Doval and the question is from Jacksonville, Florida. Alexi, the question is how can one obtain the training curriculum for VOICES?

Alexi San Doval: I believe that as part of the diffusion plan for getting this intervention out into the hands of folks in STD/HIV prevention settings, there's, as part of the webcast conference, I believe there is a fact sheet that has a number on it, a phone number, to call for information on how to obtain the curriculum, how to obtain the training materials, and also technical assistance.

Janet Cleveland: Okay, wonderful. And then I'm also going to ask Charles, since Charles is here with us at the Centers for Disease Control and can actually speak to the training issue around the curricula. You may want to address this as well.

Charles Collins: Sure. The CDC is within the Division of HIV/AIDS Prevention in our Capacity Building Branch, the four interventions that we're presenting today on the satellite broadcast, there will be efforts to diffuse those through training, technical assistance and capacity building and materials distribution. And so at the end of the broadcast there'll be a way for people to sign up for more information, for technical assistance and for training.

Janet Cleveland: Wonderful, and we'll look forward to hearing more about that at the end of the broadcast. I have a question that I'm really not surprised to hear. We thought that this one might come up, so I don't think anyone will be surprised. And that is, this question too is from Jacksonville, Florida, the person says I did not understand the differences in the bear leather community for Body Positive in the POL video.

Charles, I'm going to direct that question to you.

Charles Collins: Sure, sure. Actually, the CDC provided technical assistance to the State of Arizona to help them develop some of their Popular Opinion Leader training. And when we went into the Health Department in Arizona, into Phoenix, Phoenix is a big city and it has a fairly large number of gay men in that city. And so what we had to do was to say look, your Popular Opinion Leader program cannot really try to deal with the whole city of Phoenix.

So think about one part of the gay community in Phoenix that you can concentrate your program on, where you can concentrate and find the Popular Opinion Leaders and diffuse the intervention into that group. And we encouraged them. The success you will find from working with this group may, in fact, then lead you to success with other groups.

So when we started talking to Arizona about this we said well, what community do you think you haven't reached before, what's a community that maybe doesn't get attention? And the representatives from the community-based organizations in Phoenix and from the Health Department of Phoenix said well, you know, the bear community, that is heavier, hairy gay men, and the leather community may not be getting as much HIV prevention. So why don't we try a

Popular Opinion Leader in the nightclubs that really are for the leather community or the nightclubs for the bear community. And so we encouraged them, yes, go into those clubs and begin an intervention there and build on your successes.

Janet Cleveland: Thank you very much for that clarification, Charles. We're going to go back to the phones now and we have another question for Lydia O'Donnell, and the question is what kind of resources or staff do you need to do VOICES? And you've actually touched on this already. But I think probably this person was looking for a few more specifics, Lydia.

Lydia O'Donnell: Sure. VOICES was intended to be used in places that really didn't have that many resources to devote to prevention services. You don't really need a whole lot to do VOICES. You need a private place where a small group of people can meet and so they can have a conversation in some privacy and assuring them there is confidentiality of the group maintained. You need a facilitator who's been trained to do the VOICES program. And one of the main reasons you need a facilitator who's been trained is that it can be very difficult to run a short group session and make sure that you stay on target and you address the really important things in that group.

So, in addition to that, you need what the basics would be. Since it's a video-based program you need a TV and VCR so you can show it. And beyond that, materials for the program come in a little package that you can carry around with you in a bag that we provide. That contains both the condoms and the condom board so you can discuss the condom features and different kinds of ways of choosing condoms that can make the experience better for you.

So if you're having problems with one kind of condom, we suggest that perhaps another kind of condom would help you and your partner overcome that problem. So it's a little package that contains the videos, we have manuals that help you do it, you need a room and you need the trainer and so you can take it on the road or you can do it in a clinic. It's really very adaptable.

Janet Cleveland: That's very helpful. Thank you, Lydia, for that answer. And we're going to switch back now to Velia. We have a question for you. And this viewer would like to know how did you adapt POL to your community?

Velia Leybas-Amedia: Well, we brought the community in to help with that piece. We had a consensus panel, which is basically a community advisory board, and it was made up of several adults with background in parenting, being a parent themselves, being a school administrator or teacher, and prevention professionals. And these folks developed what are called guiding principles for us, and these guiding principles helped us in adapting our curricula. We also had a peer working group which was made up of youth leaders from the two schools we work with, and our youth leaders helped us adapt the curriculum by telling us they wanted a retreat format. It was never part of the plan, but that's what they wanted. They also wanted to have something more comprehensive and so we added sessions on puberty and sexuality, so we did that. We also adapted for culture, and one of the ways we did that is we added ceremonies, which is really important in terms of bringing people together and including the family. So we have an opening ceremony to incorporate the family and we have a graduation, again a celebration to bring in the entire family. And then we adjusted for development stage, because

we know that Kelly's work is done with adults. We had to adjust it for our young people. And so we added games to keep young people's attention and we've also adapted in terms of role modeling and skill-based activities that are appropriate for young people.

Janet Cleveland: Okay, it's very important because you're talking about young people which is such a critical community, and we actually have a viewer from Chicago who has asked the question how do you address the issue of condom use for young people, particularly those who are questioning their sexual orientation or who may be transgender?

Velia Leybas-Amedia: Well, that's where the sexuality piece is really important. Because we talk about what does sexuality really mean and it goes beyond having sexual relations. We address gender, we address anatomy, and what we do is we spend a lot of time talking about what does that mean and have a really open discussion about what that means and give definitions to our young people so they know the correct information.

And when it comes to the condom piece, we separate our young ones. We have our males in their own room and our females in their own room and we work with them that way and we give them a chance to ask more specific questions privately with others from their same gender.

Janet Cleveland: Okay, so since you've talked about the fact that you use a community advisory board, is this your program review panel or is this a separate entity that actually reviews the intervention and the associated activities?

Velia Leybas-Amedia: They do that, exactly. They review the intervention and they give us guidance in terms of what would work.

Janet Cleveland: Okay, and one last question that people may wonder in terms of what you just said. Is your curriculum, if you will, is it comprehensive in terms of health education messages? Do you include, for instance, issues around abstinence?

Velia Leybas-Amedia: Oh, absolutely. In fact, that's one of the pieces. We talk about abstinence and stress the importance about that being the surest way, the safest way, and incorporate that into our sexual health message.

Janet Cleveland: Wonderful. Thank you so much. We're going to go back to the phones and I have a question for Alexi actually. And this viewer has asked or states my agency only provides one type of condom. How could we use the condom features board with only one kind of condom available to us? And this is probably a very realistic statement for a lot of community-based organizations around the United States.

Alexi, how would you address that?

Alexi San Doval: Yes, that's actually a very good question and it comes up a lot, and having worked with various agencies we get this question raised. Well, there are two responses. One is that for the long term what we try to do is, as part of the training with VOICES, is to encourage the facilitators or agency folks who are considering adopting VOICES to really try to work with their agencies to advocate for more than one type of condom. And again, with a lot of emphasis that the approach to the intervention here is that it's a not a one-size-fits-all. And so it's

trying to provide as part of the training and encouraging the facilitators to advocate for that, for the agencies to try to get various types.

For the short term, I think that the realities playing out in clinics or community-based organizations or HIV and STD prevention settings is that people need to deal with the patient or client concerns as they come up. And one of the ways in which to do that is by knowing the different types of features that might be able to address a patient's or client's concern. Then to use the condom poster feature board to identify with that particular client or patient the type of condom that might work best for them. And then to recommend that they obtain that outside of the clinic, recommend, know what the local pharmacies carry and be able to at least point them in that direction.

Janet Cleveland: That's very helpful, Alexi. Thank you so much. I actually have another question that's just come in for you that I think also is very important in terms of populations that we work with across the United States, particularly looking at Hispanic and Latino populations. And the question is, for the Hispanic and Latino population, are the materials specific to different cultures and norms?

Alexi San Doval: The characters in the video that were selected actually for the video, we tried to take a cross-section of characters that would represent the diversity in the various in our Latino community. I mean obviously looking at the population in California versus the Latino population on the East Coast, this kind of question comes up a lot. And again, the Spanish in the video, for example, and the materials pretty much, the materials basically is what we tried to do is adapt a generic kind of Spanish for the written materials. The video obviously portrays characters that one might identify maybe not necessarily as West Coast Hispanics, for example, but certainly the Spanish is understandable and we try to adopt them using the format for the video, for example, is a tele novella [phonetic] or soap opera style, which tends to be very popular in various parts of Latin America. So in terms of the adaptability or usability of the intervention in a Mexican-American or a Central American population or South American, we tested it out in different settings and it can be adapted.

Janet Cleveland: Alexi, thank you very much. Unfortunately, that's all the time we have for this part of our discussion. I want to thank all of the panel members for their participation. I'd also like to thank all of you, the viewers, for sending in your questions. When we return, we will view two more behavioral interventions.

Julio Dicent-Taillepierre: Welcome back to CDC's satellite broadcast on Effective Behavioral Interventions for HIV Prevention. Our third intervention today is Community PROMISE developed by Doctor Nan Corby of the University of California Long Beach. Doctor Marguerita Lightfoot, Project Director from California State University Long Beach, is also here today to talk to us about Community PROMISE and its core elements.

Narrator: Community PROMISE or Peers Reaching Out and Modeling Intervention Strategies for HIV/AIDS risk reduction is a community level intervention to promote progress toward consistent HIV prevention. This is accomplished through community mobilization and distribution of small media materials and risk reduction supplies, such as condoms and bleach.

Community PROMISE is based on the AIDS community demonstration projects. The first program we visited was the Sexual Minority Youth Assistance League in Washington, D.C.

[portion of video text]

Female Outreach Worker: I'm from a youth organization called SMYAL. We're passing out safer sex kits with condoms, dental dams, lubricant.

Male Outreach Worker: If you do have sex you would always want to protect yourself. That's what we're out here for.

[end of video text]

Arthur Padilla: Our outreach workers are a great, great group of young people. They are trained and educated in a variety of different things. They get the specifics about health education and some of the stuff that's really important with regard to HIV and AIDS. Clearly, when you're a teenager and when you're a young person, having adults always telling you what you can and cannot do, what you should and should not do, you stop hearing it. But when you tell when you're friends, people that you know, people that, you know, that are leaders in your community, they tell you that this is important, then you actually start to listen. And I think that's crucial to what we do.

SMYAL is the Sexual Minority Youth Assistance League in the District of Columbia. And it's a gay and lesbian, bisexual, transgender, questioning youth drop in center, it's a youth center, and we provide a safe space for young people through skills building, leadership development, and a number of other health related issues.

PROMISE has been really important to our mission because it's allowed us to affirm a lot of the work that we have already done with our programming. In that youth are required, and it's necessary for young people to be involved in the process and that their stories and their values and their experiences are crucial to changing the behavior that young people, that their peers, are experiencing and to creating safer behavior.

Marguerita Lightfoot: What's unique about Community PROMISE is a lot of times interventions focus on the individual. Let's see if we can get this one person to change their behavior and be more safe in some way. But what Community PROMISE does, it says let's look at the community at large because an individual is part of a bigger community. And so with Community PROMISE you really are about trying to change the norms of the community. What a community does at a community level, and so the kind of impact you can see in some ways is greater because you're not only targeting an individual and saying okay, if we get these 15 people to change. You're targeting a community and saying we got this community of 3,000 people to move towards being more safe.

Nan Corby: We developed PROMISE because we were looking for an intervention that was soundly framed on good research findings, that would involve the community in the development of it, and would help people avoid contracting HIV. The first core element of Community PROMISE is one that people typically don't think of as a core element, and that is learning about your target population and the community in which you're going to implement the

intervention. The second core element of PROMISE has to do with role model stories, developing stories from the target population, about their successful efforts to prevent HIV.

Chris Griffey: One of the ways we get the buy-in to the role model stories is, one, just living by example.

Brian Conley: The way I would use my role model stories is to always ensure if I tell someone about a sexual act, I would always include condoms and whatever other type of protection that I would use and just so there could be a way of them thinking that I have to protect myself as well as the person that I'm with so that I can assure my friend's safety and like I'd also pass out condoms to my friends as well.

Female Voice: We met doing The Bad Seed in our sophomore production. He was my first boyfriend.

[Side B begins]

Marguerita Lightfoot: In the original research, Community PROMISE was used with six populations. It was men who have sex with men, female commercial sex workers, injection drug users, the female partners of injection drug users, at risk youth and communities where there is a high incidence of sexually transmitted diseases. Community PROMISE can be used with any target population, as long as you know exactly who you're trying to change. What target population you're trying to change and what kind of change you want to see in that target population, and that kind of information you get from the target population.

Narrator: The core elements of Community PROMISE include assessing community needs, recruiting and training persons to become advocates, creating role model stories based on personal accounts, and distributing role model stories and risk reduction supplies.

Patrick Piper: The M.A.S.S.K.E. Project, and that stands for Men's Awareness of Safer Sex, Knowledge and Education, was developed to target men who have sex with men who don't identify as gay. At the beginning of the project, we did a number of interviews or small surveys with people who had access to the target population. Then we went out to these bars, bath houses, arcades. And we spent time just hanging out and getting to know the community, trying to find out how people behaved and what were the norms, also identifying potential peer volunteers who would later disseminate messages for the project, for the M.A.S.S.K.E. Project.

Kees Rietmeijer: Intervention had a number of components. We had large numbers of peer volunteers go out in the communities to intervene with their peers, with the community, and they handed out something we call role model stories.

Patrick Piper: Role model stories are really small vignettes about people's experiences and we use them in our brochures which are inserted into all of our safer sex materials, safer sex kits and that type of thing. Also, we've used them as stand alone brochures. And the role model component is basically a three short paragraph description of somebody who's made a positive behavior change and they're taken from interviews with real community members.

Paul Coco: I think when I tell my story to people, no matter who they are, they really do take a second look. When they found out that I was as promiscuous as I was as a youth or as careless a drug addict, they see what happened and they're more, I think, more willing to change.

Nan Corby: In the evaluation, the early evaluation stages of PROMISE, when we asked people who they would pay attention to, whose word they would trust the most, who they felt knew their lives the best and could advise them, they always said they would pay most attention to people like themselves.

Kees Rietmeijer: The results showed, after four years of intervention, that this intervention was effective in changing behavior so that we did see an increase in condom use, particularly with non-main partners as a result of this intervention.

Paul Coco: My story, I found out I was infected with HIV when I was 24 years old in 1988. It wasn't until two years ago that I really showed signs of being sick. Last year, I almost died, but I've changed. I've become a lot more serious about a lot of things. I hand out more of these kits than ever now for two different agencies, I keep them in my home and I have drop off spots all over town, and I do the same with condoms. The importance to others is use your common sense, protect yourself and others. "You never know." And that's a true quote, you never know whose got what disease and if they're telling the truth.

Corinne Matthews: Thank you, Doctor Corby, Doctor Lightfoot, SMYAL and the M.A.S.S.K.E. Project for their participation. Our fourth intervention is the Mpowerment Project. The Mpowerment Project is a community building program designed to reduce the frequency of unprotected sex among young, gay and bisexual men by having the young gay men take charge of the project. Doctor Susan Kegeles from San Francisco, California, has joined us to discuss the core elements of Mpowerment.

Jane Bopp: A lot of people do say oh, you're so isolated and it's paradise, but again, everyone wants to come to paradise so we have tourists who are coming here from all over the world and who can be bringing HIV. They come to Hawaii, they think of paradise, they're here, they're having unprotected sex. In Hawaii, the majority of our population are people of color, about 65 percent are people of color. And so that idea that HIV isn't in their community, Hawaiians don't have to worry about HIV, Filipinos don't have to worry about HIV, Japanese don't have to worry about that. That idea is still subtly there, and that's something that we're combating.

Susan Kegeles: There are five core elements of the Mpowerment Project. The first one is formal outreach, which involves going to venues where young gay and bisexual men congregate and also involves developing outreach social events, which will attract young gay and bisexual men.

The second core element are M-groups, and these are one-time groups that young gay and bisexual men attend that focus on their personal risk taking behavior as well as on taking the message about safer sex to their peers during the course of natural conversations.

The third core element is informal outreach, and that's what they learn in the context of the M-groups, about how to support their friends about the need for safer sex.

The fourth core element of the Mpowerment Project is publicity, and this is done within the young men's community itself. It's done through word of mouth, through small written materials that are handed out and so forth.

And the fifth core element of the project has to do with the space where the project is conducted. This is the headquarters for the project and provides a safe space for young gay and bisexual men to congregate.

Jason Mossholder-Brom: Before IKON was implemented in Honolulu, young gay men, young gay and bisexual men, didn't have a lot of social options and really, other than the gay clubs for the under-18 set and the gay bars for the over-21 set, there weren't a lot of positive social options and there's a lot of pressure in the bar and club scene. The pressure is to meet somebody, hook up, get high. And by providing these kinds of social alternatives it really is giving the young men's community an opportunity to bond and to create relationships that don't have that pressure and don't have the kind of sexual and social pressure and intensity that they do in the club and bar scene.

IKON was first developed as a means of reaching the very high-risk young men who have sex with other men that the other programs at Light Foundation weren't reaching. We had some really effective outreach programs that were reaching Asian Pacific Islanders, high risk women, transgender people, but we were finding it very difficult to attempt mobilization, so to speak, of the young men's community. And we knew that they were there, we knew that they were out in the clubs and the bars, but in terms of mobilizing and empowering that community as a group we knew that a community level intervention would probably be the most effective in reaching those young men.

Jane Bopp: I think the most important think about making an intervention culturally appropriate is to have members of the culture or the ethnic group, the target population that you're focusing on, the paid staff at your agency as well as be the individuals who are part of the core group, who are part of implementing the intervention.

Susan Kegeles: A major guiding principle of the Mpowerment Project is that the message is diffused throughout social networks within the young gay men's community. This becomes a self-perpetuating process where young men talk with each other and encourage each other to be safer and then bring their friends back to the project and then their friends hear this message about safer sex and bring this message back to their friends. And so through this mechanism, the message about safer sex becomes diffused through all segments of the young men's community.

Jason Mossholder-Brom: IKON utilizes all the core elements of Mpowerment, but what I've found to be necessary is that it's been really important to, as fully as possible, turn this project over to the core group. And the core group has been very effective in making the modifications that are necessary to make this project fit our community.

Jane Bopp: At the Light Foundation here in Honolulu, I only hire peer staff at my agency. That's the way that I'm able to reach the kind of target populations that we're trying to reach, that we're trying to work for. And use peers who are from that community, of that community and who have had the similar life experience of the people who we're trying to reach.

Susan Kegeles: One challenge that we've encountered with the Mpowerment Project is that it's not always easy to get men to attend the M-groups. And this is very similar to what a lot

of other HIV prevention programs are encountering these days, so we've used multiple strategies to overcome this problem. One thing is that the program is multi-faceted so we don't just rely on small groups, and that's why it's very important to have multiple components of the intervention including social events and so forth.

A second strategy we've used is to promote the small groups as focusing on other issues rather than only safer sex. And indeed, the groups do focus on other issues. They focus on what it's like to be young gay men in this era.

Jane Bopp: I find this work very satisfying because I am able to help people to help themselves, to help them change their own lives so that they're able to go out and affect the lives of others, and that's very gratifying for me.

Jerry Cheney: We at the New Mexico Department of Health are really concerned about the populations at risk in our state and, like many Southwestern, Mountain and West states, men who have sex with men have the highest rates of HIV infection and we are always looking for new ways to address the epidemic.

Susan Kegeles: What young gay men are interested in is meeting other young gay and bisexual men, having fun, being able to just be themselves, be relaxed with each other. And so our program builds on that idea. There are a number of things that I think it's important for agencies to consider when implementing the Mpowerment Project.

The core group is the decision making body of the project. These are a group of young gay and bisexual men, usually 15 to 20 men, who make all of the major decisions about the project within the parameters of the core elements. They make the decisions about what kinds of events to put on, what to name the project, what the image of the project should be in the community and so forth.

John Hamiga: Mpower's main pull is that we are a gay men's, gay and bi men's, community center. It's one of the first places they can come and contribute to their community in a positive way. There's no alcohol, it's alternative to the bars. What we've done here in Albuquerque is we've empowered the guys to feel that they're making a change in their community. Also, that they're going out and have the same responsibility as coordinators, that when they make a successful event at the house or go out and do a successful event for outreach, that they are saving the lives of their friends. Before they came here, they would never realize how important it is to talk to their friends about safer sex. And now they do and that changes things in the community.

Jerry Cheney: One of the problems that I think folks recognize across the country, particularly when you get into smaller cities and more rural areas, is that the gay community or gay communities aren't really organized and to try to design interventions to random folks out there in the community is very difficult. Whereas Mpower creates a place for them to come to find mutual support form their peers and from caring adults and to not only learn about who they are as young gay and bisexual men and transgender folks, but also learn about both the risk that are out there and the positive things that they can access to reduce the risk.

Susan Kegeles: This project space is where most of the activities are conducted. It can serve as a drop in space and, most importantly, it's a safe space where young men can congregate and be with each other and just be themselves. It also provides an alternative space away from the bars, which are very sex charged and difficult atmospheres for many young men and it's not exactly a conducive place for community building for young men.

Matthew Reed: Not all gay men are raging alcoholics or drug abusers or just going out jumping from partner to partner. There are more social settings beyond that, and that's one of the things Mpower has helped me to realize is that I don't need to go to a bar necessarily to have a friend. Mpower has basically allowed me to go out there and basically be proud of who I am, not just as a gay Native American, but as a human being.

I never really noticed any racial barriers or racial lines and the guys here, we're not segmented, like all the Native Americans hung out together, African Americans hung out together, all the Caucasians or whatever. It was just all intermixed and we were all here together, because this is the safe place.

Susan Kegeles: I feel impassioned about the Mpowerment Project. I have seen the impact that the project has had on many, many young gay man. And I've spent the last 13 years working on it. It thrills me to think that the project is being picked up across the United States and, in fact, in different parts of the world as well. My work partner, Robert Hays, who died a year ago of AIDS, spent the last 13 years also working on it and he committed his life to it. So to see that the incredibly hard work that we've spent on this project is really meaning a difference in young men's lives means everything to me. It makes my work worthwhile.

[a short tribute to Dr. Hays is shown]

Narrator: Now, let's review the core elements of the Mpowerment Project. Recruiting a core group of young gay men, establishing a project space, conducting outreach, sponsoring social events, convening one-time discussion groups and conducting a publicity campaign.

Julio Dicent-Taillepierre: Thank you to Doctor Susan Kegeles, the Mpower Project in Albuquerque, and Light Foundation in Honolulu. We will now begin our second panel discussion. Here, once again, is Janet Cleveland.

Janet Cleveland: Thank you, Julio. Welcome to our second panel discussion where audience members will have the opportunity to ask questions regarding Community PROMISE and Mpowerment Project. We are pleased to be joined by Arthur Padilla, Executive Director from the Sexual Minority Youth Assistance League in Washington, D.C., and also Jason Mossholder-Brom, IKON and Prevention Case Management programs, coordinator from the Light Foundation in Honolulu, Hawaii.

Also joining us by phone are Doctor Nan Corby, Principal Investigator from the University of California at Long Beach and Doctor Marguerita Lightfoot, Project Director at the University of California Long Beach, and Doctor Susan Kegeles, Associate Professor, School of Medicine, University of California at San Francisco. Let's begin with Arthur. Arthur, obviously the role model stories in PROMISE are very important and very critical and the first viewer would actually like to know how do volunteers hand out these role model stories?

Arthur Padilla: Volunteers hand out the role model stories by we actually have them written out and they're typed up and they're usually put in pamphlets and then those pamphlets are incorporated into the packet and then they hand them out. At the same time that they're handing out the role model stories, they're doing a little bit of conversation and we try and do a little bit longer interventions, a little bit more than 30 seconds we're doing.

We're trying to do five to ten minutes, and that way they can actually have a conversation. And in that conversation they also deliver the same role model stories where they talk about what they've done to actually delay sexual activity or to have safe sex, either one, whichever the role model story is that the youth is using. So that's usually how it works.

Janet Cleveland: Okay, thank you very much.

Arthur Padilla: Sure.

Janet Cleveland: I'm going to play off of your answer actually and go to the phone where we have a question for Doctor Nan Corby. Nan, this viewer would like to know how many role model stories does a program actually need to get started?

Nan Corby: You only need one role model story to get started, but it's pretty easy to get two or three role model stories out of any given interview with a target population member. The way the PROMISE package has been put together, each component of the package has a good, better and best level of implementation depending on what your resources are. If you have few resources and want to start off slow, you try to start with the good, and as your resources and expertise grow you can move on to the better and best if you'd like.

Janet Cleveland: Okay, very good. Thank you so much.

Arthur Padilla: Can I add something to that?

Janet Cleveland: Please do.

Arthur: One of the things that we do that's really important is that we have really worked with young people to develop their own role model stories, so they might have something that's printed that's actually gone through the review panel, so on and so forth, but they're also trained to talk about their own story so it's related one-on-one. And that's just an enhancement that we've done because it's really important working with peer educators and getting them out into the community for them to have a real . . . it's genuine. It creates that genuine interaction that's really important to this particular process.

Janet Cleveland: Thank you very much for that. Arthur, you actually bring up a specific point that we've already received several questions on, so it's probably a good time for us to go ahead on and address this particular issue that you've actually just identified and that is the issue of the program review panel. I'm actually going to ask both you and Jason if you would address how you've addressed issues around your interventions in terms of your program review panels in your local communities.

Arthur Padilla: Okay, well clearly the program review panel for us is the first place. After we've started to develop our material, we send them to the program review panel for them to look for the technical aspects. And also look for the relevance to the model that we're using or to the prevention that we said we were going to do and then also how that relates to the

community planning group and so on and so forth. So they do a number of things and all of our role model stories, all of our printed video material, surveys, all of those materials have all gone through the program review panel prior to implementation.

And with the young people working with their stories when they're doing the actual conversations, they're following the same basic guidelines of the program review panel. And I know that there's some information on this broadcast regarding where they can find those guidelines and the youth are given those same guidelines when talking about their own personal stories. So that's how it's implemented for us.

Janet Cleveland: That's very helpful. And Jason, would you please address that as well?

Jason Mossholder-Brom: In terms of the Mpowerment model, the core group is always the guiding force for Mpowerment and we have utilized our community review panel in terms of kind of advisors to the core group. So the core group will make the primary decisions and then receive sort of the wisdom, the elder wisdom, of the community in terms of reviewing especially our media materials, our written materials, our advertisements.

Janet Cleveland: And you bring up a very important point that is somewhat unique, of course, to your community, but I'm sure also is indicative of other communities across the United States as well. And that is the role that elders play. So not only are you talking about having to go through a review process with your program review panel, but also the fact that your elders within your community have to also buy into what it is that you're actually doing.

Jason Mossholder-Brom: Absolutely, Janet. What we call in Hawaii the concept of Ohana, or family, is very important, and we're not just necessary speaking of biologic family but rather more the extended community and the aunties and uncles that play a really important role in guiding young people's lives in our community.

Janet Cleveland: Thank you very much. We are now going to go back to the phones and I'm going to direct actually this next question to Doctor Susan Kegeles. And Susan, we've received already several faxes from viewers who are interested in how Mpowerment can be adapted to various communities. Specifically I have questions here regarding how Mpowerment can be adapted to adult populations as well as MSM of color populations and then also minority heterosexual young people. Would you please address that?

Susan Kegeles: Yes, hi.

Janet Cleveland: Hi.

Susan Kegeles: Well, I think the clearest easy adaptation would be to MSM of color populations. The major decision makers for the intervention is the core group and when you make sure that the core group represents the different segments of the community that you're trying to target and they're making decisions, then they can make decisions that are very appropriate for that particular group. And we have always found in every community that we've implemented the intervention and within our discussions with our community partners that when they make sure to have men of color as part of the core group and the decision makers of the project, then they make culturally appropriate decisions about how the program should be

positioned. What kinds of activities to be doing, what kinds of outreach publicity materials, what they should look like and so forth.

For older men, and by older I don't necessarily mean old, just guys over 30, there have been a lot of discussions we've had with people saying this is a very interesting idea for us as well. We want a sense of community. We want a time to get together and a place to get together and so forth, and so we have encouraged that people consider how it should be tailored. But just as the way that we approach this right from the start where we did focus groups, in-depth interviews with young gay and bi- men and so forth, we think it would be very important that that kind of process be conducted so that it really is implemented in an appropriate way for older men.

For heterosexual minority youth, I think certainly some of the core elements would apply. It makes sense to implement a community level intervention and to try to reach all young people in a community and to mobilize young people to speak with and encourage each other to have safer sex.

And the guiding principle, a guiding principle, of our program is that the intervention should serve an empowering function in the community and that young people should take on these issues about safer sex themselves, not just do it because someone else tells them to talk to people.

I think that's very relevant for young people, young people of color, and so I think the decision-makers in a program, if it was going to be adapted for this group, should also be young heterosexuals of color. But again, you need to go through that kind of formative research, needs assessments and so forth, to figure out how it should be tailored.

Janet Cleveland: That's very helpful. I'm going to ask Jason if he would respond to that as well, because questions that we often receive actually deal with the issue of fast tracking in terms of research. And we certainly know that there are communities that are being severely impacted by HIV and AIDS right now that there's a dearth actually of research that's been done on those populations. And so in terms of looking at adaptability issues, how did you handle that in Honolulu?

Jason Mossholder-Brom: Well, in terms of looking at the community that our project services, I mean we're looking at an extremely ethnically diverse community and I can just really second Doctor Kegeles' remarks regarding, again, turning it over to the core group. And our core group is comprised of young men of all kinds of ethnic backgrounds. We have many Asian Pacific Islanders in our region and by including representatives of that group on our core group, again, we're not making the decisions.

We, as a group, are receiving input to encourage cultural competency and providing activities, social opportunities that are going to be attractive to all of these different ethnic groups. So in terms of adaptability for us, the core elements have always been our guiding principals, but by using very active use of the core group. That's what has made our projects attractive and interesting for the community that we're trying to service.

Janet Cleveland: Okay, and while we're on this very important issue of adaptability, I'm going to ask you, Arthur, what would be your words of wisdom in terms of dealing with issues around adaptability for maybe, say, PROMISE?

Arthur Padilla: I think that everyone has really talked about a lot of the most important pieces and for me it is bringing in the community that you're working with to assist you in developing the program and to give you some guiding reinforcement over the long term and doing evaluation and questioning with that particular community so that actually you get the information back of whether or not it's being effective, whether they like it, does it make sense? All of those things, bt bringing in the community is crucial and working with the community that you're targeting.

So, again, I think all of the models are very adaptable to almost any community if you're bringing them in and having serious, long-term conversations. And, again, going back to that formative evaluation piece of really talking to the community, doing some real investigation of gatekeepers and so on and so forth, all of those really principle parties for whom the community is affected by and who they interact with.

Janet Cleveland: Critical.

Jason Mossholder-Brom: And I guess my comments on that as well would be it's vital to remember that process not just when you're starting the intervention, but also as you're going along, you know, going back to the communities, finding out what's working, what's not working and continuing to adapt and change.

Janet Cleveland: Great. Thank you all very much. We're going to go back to the phone and I actually have a question for Doctor Marguerita Lightfoot. And Marguerita, this viewer would like to know what kinds of health behaviors are best suited for the role model stories?

Marguerita Lightfoot: That's a really good question and I would say, broadly, all health behaviors, because what you're doing in the first core element of the intervention is figuring out where the community is it. Are you looking at a community that's not using condoms at all, not even thinking about using condoms?

Well those are going to be very different role model stories that you're going to be developing in comparison to a population where they're using a lot of condoms, but maybe not consistently. And so the kinds of behaviors that the original research focused on was condom use with main partners and non-main partners, as well as not sharing one's [inaudible] and cleaning your needles.

I think that the role model stories that work with reducing sexual partners with abstinence or a number of different behaviors, because really the stories that you're using come from the community. So wherever the community is at, whatever behavior that needs to change in order to make the community more safe, that's the behavior that you're going to choose to write role model stories about.

Janet Cleveland: That's very helpful. Let's go back to Arthur, and Arthur, specifically we have some questions about outreach workers and this viewer would like to know what safety precautions are actually taken for your outreach workers in your program.

Arthur Padilla: Good question, actually, and it's really important that the work that we do, that we really take into account who is doing the outreach and what time and so on and so forth. Most of the outreach workers that we have go out with adults and we have adults on staff that are outreach specialists who train and coordinate these young people to actually do the work. And when they do go out, they go out with that adult or a number of adults. And we also have adult volunteers who go out and support the youth in their work. They don't actually do the outreach, but they will go with them on the Metro and wherever, however they're getting there, and they will sit and monitor and make sure everything is okay.

We also do a very comprehensive outreach training, which is about 16 hours worth of training before they actually are taken out into the street. And then once they are out in the street, they're paired with an outreach worker who has had a lot of experience.

So those are a number of the precautions that we take. We always try and get parental consent with people that are under 16. We very rarely have young people under 16 going out into the street. If they're doing outreach it's either in the community center that we're in or in their schools or so on and so forth, in very, what would I say, very closed environments and safe environments. Most of these that are going out into the streets are between the ages of 16 and 21.

Janet Cleveland: Our next question is actually for Jason, and Jason this viewer would like to know why is it so critical that a safe place is needed for Mpowerment?

Jason Mossholder-Brom: I think that's a really good question and I could answer that in a couple of different ways. One of the principles of Mpowerment is to provide an alternative physical location to the kind of the club and bar scene. And to really provide that effectively there needs to be a location that the young gay and bisexual men can congregate in, you know, kind of a headquarters so to speak.

We're quite lucky in the fact that we have been using a space in our foundation offices and are able to hold most of our events there. And it just provides a really good foothold, you know, and we've found that that really encourages the young men feeling emotionally safe, that there's always a place that they can go to. And a lot of our preparation of our media materials, putting together the safer sex kits, is also done at the same location, so it's really a headquarters for the project.

Janet Cleveland: In the film footage that we saw earlier, Jason, we saw where there were a lot of social activities.

Jason Mossholder-Brom: Correct.

Janet Cleveland: That the group was actually involved in. And I'm just wondering if you could clarify for the audience how you actually infuse health communication messages into those activities.

Jason Mossholder-Brom: That's another good question, Janet. Diffusion, this theory of diffusion, is, of course, kind of the guiding light behind Mpowerment. As Doctor Kegeles was talking about in the footage, what do young gay men want? They want to meet other guys that they can hook up with. By providing these social opportunities, it also provides us an

opportunity to do informal training about our message. And as you're watching our social activities, you start to see these small conversations pop up around safer behaviors. And it gives an informal opportunity for the messages to be diffused to these young men that are attending the events and then take that message and take it out to their friends back to the bars, back to the clubs.

And the social events are what draws participants to the project. They don't want to come to a safer sex workshop. They want to come to a barbecue. They want to come to a bowling night. And then once they find out, hey, this is a group of young guys that's cool, I want to hang out, then we're a lot more likely that we can bring them into the M-groups and to the real core functions of the project.

Janet Cleveland: Great, thank you very much.

Jason Mossholder-Brom: Sure.

Janet Cleveland: This question actually has to do with evaluation tools, and for both Mpowerment and PROMISE the question from Chicago is what evaluation tools are used to measure the effectiveness of both Mpowerment and PROMISE and then also what is actually measured? So why don't we start with you, Arthur?

Arthur Padilla: The evaluation tool that we used initially, we call it a Risk Assessment Tool or a RAT, which is actually fun. We run around saying where's the RAT, where's the RAT? [laughter] And the RAT, the Risk Assessment Tool, was based on the stages of change model. And we're looking for individuals to see where they are on the stages of change and then we look at them again over the long term, usually within a six-month period to a year-long period, to see whether or not they have moved along that continuum.

And I know there's information about stages of change if people need to get that. They can get that on the web. So that evaluation was done initially from the formative evaluation and, again, that goes back to doing that needs assessment prior to implementing the program so we know where everyone is at.

And we did a large number of youth, both inside the center and in the community, and then we went and we'll do it again in six months and we do it again at the end of the year to see if there's any change. And so that's kind of how we're measuring it.

The tool is fairly comprehensive, it's a little bit difficult, and for young people it's a challenge to fill out. But we're looking at a lot of things. We're looking at behavior, we're looking at drug use, we're looking at family. We're looking at a whole bunch, a variety, of different issues in order to determine what are some of the factors leading to unprotected sex, so on and so forth, and are we having any effect with those factors?

And again, the risk assessment was done for a number of different programs, so the PROMISE model was fit into that risk assessment. So we look also at smoking and strength-based stuff, so we're looking at a number of different issues and that's kind of how we did it.

Janet Cleveland: Comprehensive.

Arthur Padilla: Yes, comprehensive.

Janet Cleveland: Okay, great, thank you. Jason, would you like to address that as well?

Jason Mossholder-Brom: Just briefly, we use a similar tool that's based on the stages of change model. Participants in various activities will fill out evaluations following the activities that also do some measuring of their risk behaviors and that gives us an opportunity to track over a months' period what types of changes are being made and how the population is being served by the project.

Janet Cleveland: Okay, wonderful.

Susan Kegeles: If I may speak up a second?

Janet Cleveland: Yes, please.

Susan Kegeles: I wanted to add in that, of course, the initial ways that we studied this project were through sort of big science and studying various communities, and that's prohibitively expensive for community-based organizations to do that kind of evaluation. So we did some further investigations to find out the methods that community-based organizations could use and did want to use and that funders would find acceptable. And that's now part of our package. So specific measurement approaches and methods are part of our replication package at this time, and we suggest using spot interviews before the intervention gets under way and then continuing to do spot interviews periodically over time.

But we also think that it's very important to pay attention to evaluating fidelity to the intervention's core elements and guiding principles and that this is just extremely important that the organization spends time really assessing if they're doing what they're hoping to be doing.

Janet Cleveland: In terms of knowledge and measurement of knowledge and behavior, Nan, could you just follow up on that just a little bit? This viewer had a specific question about tools that you use to measure knowledge and also this person wanted Susan to answer this question as well.

Nan Corby: Hi, this is Nan. The Community PROMISE model did not measure knowledge. We are less interested in what people know about HIV than in what they're doing about it. So we're looking at behavior and we did measure, as many of the other programs did too, how people are progressing along with stages of change with regard to the particular target behaviors that we're trying to get them to adopt.

Does that answer that?

Janet Cleveland: Yes, that's very helpful. Thank you.

Arthur Padilla: Can I add just a little piece about that, that we have done, because we do such comprehensive education with our youth outreach workers and we have such a large number of youth outreach workers, we're able to do some knowledge assessment. But that's the only time with the PROMISE model that we're able to do that. I just wanted to support that we're doing what the researcher has intended that we do, that we're looking really at behavior. And that knowledge is really important when we're doing the outreach so that young people are delivering the correct and appropriate information, but really we're looking at measuring the community as far as stages of change are concerned.

Nan Corby: I would like to say a little bit about knowledge. For many of the populations who have been getting a lot of AIDS education, their level of knowledge is so high to begin with

that you won't show any change in knowledge as a result of your intervention. And so looking at behavior is sort of the bottom line anyway, it becomes much more important.

Susan Kegeles: Right, and I want to agree with that. This is Susan Kegeles again. We also found in our research that the level of knowledge among many young gay and bisexual men is very high already. And that it isn't particularly predictive of who engages in safe or unsafe sex given that knowledge is very high, but that other kinds of variables do predict who engages in unsafe sex and we did measure those.

So, for example, we found that beliefs about how enjoyable safer sex was increased over time on the basis of our intervention by comparison to the control community. So we tend to look at other kinds of variables other than knowledge.

Janet Cleveland: Great, thank you both so much for addressing these important issues and thank you to our panel members. I'm afraid that, again, that's all the time we have for our panel discussion. I want to thank our panel members for their participation as well as the viewers for sending in your questions for the panel.

Corinne Matthews: At this point, you've now seen four effective behavioral interventions, VOICES or VOCES, Popular Opinion Leader, Community PROMISE and Mpowerment Project. We will know hear from Doctor Charles Collins on how you can receive training and technical assistance to implement these interventions.

Charles Collins: I would like to thank all of the programs and researchers featured on today's broadcast for allowing us to share their excellent work. We hope the information presented has demonstrated the breadth of these interventions, as well as several examples of the ways the interventions can be adapted and tailored to different populations. If you would like further information on any of the interventions presented on today's broadcast, please visit the broadcast website at www.effectiveinterventions.org. Here, you will find information fact sheets on the interventions seen on today's broadcast.

This broadcast is one part of the Technology Transfer Project. The purpose of the Technology Transfer Project is to provide high quality trainings and ongoing technical assistance on science-based effective interventions for HIV prevention to state and community level program staff. As part of the Technology Transfer Project, the Capacity Building Branch will be offering training, ongoing technical assistance and other capacity building support that is needed to implement these interventions in communities across the nation. There will be multiple training in numerous regions around the country.

For additional information on training or technical assistance on these interventions, please fill out the training sign-up form. Be sure to include your contact information on the form. You may obtain the form in one of the following ways. One, from your site coordinator at your viewing site. Two, on the broadcast website, www.effectiveinterventions.org or three, by calling 800-462-9521 or 202-884-8712. Thank you, and we look forward to the opportunity to work with you.

Julio Dicent-Taillepierre: Thank you, Doctor Collins. And that brings us to the end of our broadcast. Thank you for your participation.

Corinne Matthews: If you are interested in receiving training and technical assistance on any of the interventions featured on today's broadcast, please don't forget to complete the training sign-up form and fax it back to 877-884-9342. Finally, if you would like to order a videotape of today's program, please contact the satellite broadcast hotline at 800-462-9521 or e-mail interventions@aed.org.

Please mark your calendar for CDC's next satellite broadcast on HIV prevention scheduled to air November 21st from one to three p.m. Eastern time. That broadcast, titled Public-Private Partnerships and New Models for Community Mobilization Against AIDS, will discuss activities and resources for businesses in partnership with health care agencies and community organizations. You may obtain information about that broadcast after August 1st at the broadcast website, www.cdcnpin.org/broadcast, by dialing CDCFAXX, enter document number 130043 and a return fax number, or by calling 800-458-5231.

And that brings us to the end of our program. We'd like to thank all of the panelists for their participation in today's broadcast. We'd also like to thank all of the researchers and programs featured on today's broadcast. And thank you to the site facilitators and viewers for your efforts in setting up viewing sites and for participating today. We hope the information presented on Effective Behavioral Interventions for HIV Prevention will be useful to you in your programs. We look forward to our partnership with you in our efforts to improve the diffusion of effective HIV prevention interventions.

Good day from Atlanta.

[end of transcript]